Labor reintegration: A nonlinear process

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Abstract

The objective of this article is to present a reading of the labor reintegration process. This study addresses the labor reintegration process of people who return to work after having been disabled for long periods of time regardless of the origin (common or work). This phenomenon has received different names in Spanish: reincorporation, return and reintegration. Thus, it has been difficult to understand. In some studies, it has been viewed as a result, while in others, it has been viewed as a process.

Method: A qualitative study was conducted using the biographical method and the discursive interview technique with 11 participants. Content analysis and narrative lines were used.

Results: Labor reintegration is a complex, multidimensional, multitemporal and multidirectional phenomenon. It is not a single process. It can entail multiple processes, since it depends on the experiences of those who live it, the contexts and the organizations where it is developed in a regulatory-administrative process that begins with the end of the period of labor inability, whose onset occurs with the same health-disease event.

Conclusion: The phenomenon must be understood in terms of the psychosocial aspect and transcend the normative reading related to safety and health at work. It must shift from being a model focused on insurability to a model focused on workers’ health.

Introduction

Returning to work after a labor inability is one part of a complex, multidimensional phenomenon known as return to work (RT), in which different actors and organizations participate [1, 2, 3, 4]. Return to work involves a constant exchange of information, expectations and meanings, along with agreements to fulfill and evaluate to advance what is useful for the employee and the employer [1].

Different theoretical models of health address the issue of return to work, including the biomedical model, the forensic or insurance model, the psychosocial model, the ecological or case management model, the economic model, the ergonomic model and the biopsychosocial model [3–5]. Generally, these models focus on the reintegration of people with occupational disabilities.

The RT process is influenced by personal characteristics, forms and conditions of work, which leads to involvement of different actors and institutions [6, 7]. Research has found that these factors concern the physical and psychosocial characteristics of work, such as heavy work, physical work, repetitive and continuous effort, musculoskeletal tension, physical conditioning, uncomfortable work positions, and exposure to noise, among other issues related to prolonged labor inability [2–8, 9].

At the organizational level, there has been extensive research on employer factors that are predictive of the duration of labor inability, including a people-oriented culture and an organization with a proactive return-to-work program with a positive safety climate and ergonomic design practices [10, 11, 12]. Other factors are early intervention activities, such as case management, compensation coordination with the primary care provider, accommodation evaluation, work modification, supportive exercise, and a return to activities prior to the injury, evaluated through motivational interviews and cognitive behavioral interventions [13].

Research has also been conducted on social policies and macrostructural economic factors that affect the duration of labor inability. Litigation, the complexity of the compensation system and dismissal during sick leave have led to prolonged labor inability, while a large number of work benefits have tended to shorten labor inability [2–14, 15].

Other studies have shown that work is characterized as a necessity, a source of pleasure, recognition and socialization [16]. Work activity is considered to guarantee material subsistence and active participation in society. It is also a source of suffering due to the feeling of exclusion and social segregation. Although work alludes to negative feelings, it is felt as something positive, and health professionals should therefore facilitate a return to work [12–17].

Different studies address aspects concerning RT regarding the positive impact of work on people's health [18], the construction of expectations and perceived uncertainty [12–19]. In relation to the RT process, a linear perspective was found in the literature. In this manner, there are some steps, first taking into account the worker's recovery period, a second contact with the worker, a third contact to evaluate the worker and work tasks, and a fourth contact to develop the return-to-work plan with accommodations, followed by the resumption of work and a final follow-up to determine reintegration progress [20, 21]. Due process must be complied with because there are challenges for the individual, the company, and colleagues; thus, a connection should be made at an early stage [22].
Finally, studies of RT have focused on workers before they return to work [21, 22, 23]. Other studies have focused on the opinions of health professionals regarding facilitators who participate in the labor reintegration process [24], and in other studies, the interest has focused on workers who are active again after periods of labor inability [7–12–16, 17, 18, 19–25, 26].

In this sense, this article presents an approach to work reintegration as a multidimensional and multidirectional process, considering the voices [27, 28] of workers who experienced long periods of labor inability and returned to work.

**Method**

**Type of study**

This study has a qualitative design that uses the biographical-narrative method with discursive interviews; thus, the method is essentially narrative [29], and its purpose is to understand the process of work reintegration from the worker's perspective.

**Participants**

Eleven people who had experienced long periods of temporary labor inability were enrolled as participants. The majority of participants had exceeded 30 days of labor inability. Two participants had suffered traffic accidents, and two participants had a common disease. Six participants had experienced work-related accidents, and one participant had experienced two accidents, one of common origin and another work-related accident.

**Information collection technique**

The discursive interview was used [30] because it allowed us to understand the phenomenon to be investigated and to gather biographical information directly from participants when they spoke about their experiences with the labor reintegration process.

**Data analysis technique**

Two analysis techniques were employed: content analysis [31] was used as the recording unit, that is, the unit of significance to be coded (the word, the topic, the character and the event); these units were counted according to the frequency, the presence or absence, the intensity, contingency or co-occurrence [31].

The second technique, narrative lines [32], is based on a theoretical-methodological approach to social constructionism, which “allows schematizing the contents of stories used as illustrations and/or identity positions in the course of the interview” [32]. It allowed us to understand and locate the stages in a timeline of the processes shared by participants during interviews.

In this study, aspects related to the topic are addressed, the characters are mentioned, and the event is discussed. The understandings of the RT phenomenon are presented with narrative lines.

**Categories and subcategories of analysis**

To understand the phenomenon and identify the different ways in which it can be read from listening to the voices of workers who relayed their RT processes, five categories of analysis were established. The first four were conceptual, and the fifth was emergent. The first category was the labor reintegration process, which has four subcategories: health-illness, time period of labor inability, end of labor inability and arrival at the workplace. The second category was social support. The third category was personnel level. The fourth category was working conditions, and the emerging category was the Colombian health system. For the purposes of this article, only the results obtained in category 1 labor reintegration process and the respective subcategories will be presented.

**Ethical aspects**

The deontological and bioethical code of psychology, Law 1090 of 2006, Title II, article 2, paragraphs 6, 9 and Chapter IV, article 49, 50, 51 of Colombia were followed [33].

Accordingly, the following criteria were applied:

- An invitation to participate in this research was issued. Individuals interested in participating in the research signed an informed consent form, and their information was handled confidentially.
- During interactions with participants, attitudes that conditioned participants’ responses were avoided.
• The recorded information was carefully saved, and participants were guaranteed the right to anonymity.
• Risk management was considered, taking into account the principles of nonmaleficence and beneficence established for conducting research with human beings.

Results

To arrive at the approach to work reintegration processes, the results are presented by subcategories. In the health-illness subcategory, the following aspects were considered: the event or health event that gave rise to the incapacity for work due to illness or occupational or common type of accident, associated symptoms, treatment, and evolution, among other aspects. It is possible that after the health or illness event, the life of the person changes direction because in most cases, their usual routines vary, as mentioned by P7: "I no longer get up to go to work, but to go to therapy".

The change in direction, which was more visible in some cases than in others, is due to the change in the rhythm of life and the relational dynamics that the individual establishes based on his or her capacities and interactions with others (organization, work, bosses, colleagues, family and others). For example, when talking about his experience, P3 mentioned that "at the beginning, it was the discomfort because it was enormous. I couldn't move my arm at all. Thank God I'm right-handed, not left-handed, but nevertheless, the discomfort is quite a lot". The individual became aware that his abilities had been altered by the health-disease event. In some cases, depending on the injury, the individual does not improve or continues to feel pain and a lack of mobility independent of the pharmacological or therapeutic treatments provided, as happened with P2, who said, "I felt useless".

Finally, 11 participants reported the absence of psychological support, and attention was focused on organic and functional recovery without the psychosocial component. The health professionals who accompanied the process were doctors and specialists such as physiatrists, psychiatrists, neurosurgeons, neuropsychologists and physiotherapists. At no time did they allude to the professional in psychology; in addition, when talking about their experiences, they mentioned that it would have been important for them to have therapeutic support from psychology but that at no time was it provided during their process of labor reintegration. As P11 said, "I have not had psychological support".

Period of labor inability

In this subcategory, the duration of the labor inability was taken into account; if there were extensions, the different activities that the person performed during that period were also considered, such as attending therapies and medical consultations.

Analysis of the interviews showed that the period of labor inability sometimes begins when the health-illness event occurs (see Illustration 1) or later (see Illustration 3). This situation occurs due to different factors. First, how early is the diagnosis of the case with respect to the course of the disease? Second, what decisions do health care professionals make and based on what medical criteria?
Third, the administrative procedures differ according to whether the case is common or occupational. If it is common, it will be managed by a health service provider entity (EPS); if it is occupational, it will be managed by an occupational risk insurer (ARL). Thus, the person must work during a period in which, possibly due to his or her health status, he or she should have had a period of labor inability, as was the case of P4: "... It took 5 months. During the 5 months I was working with pain, the diagnosis was ligament and meniscus rupture...". P5: "The injury was in September 2018 and I had surgery in 2019 in April; it was 8 months before I got the operation".

The results also made evident that disabilities do not cure themselves. If a disabling event is not accompanied by a treatment, there will be no recovery, as was the case with P6: "The second occupational doctor to whom they sent me to simply extend my labor inability because there were still no dates for my exams got upset. He told me that they should have sent me for exams urgently ...". This finding is consistent with that of a previous study that found that if the period of labor inability is not accompanied by adequate treatment to ensure the worker's recovery, it will not be sufficient: "The fundamental purpose of medical care is to restore health, optimize functional capacity and minimize the destructive impact of the injury or disease on the life of the patient" [34]. "There is disarticulation in the care processes that require patients to go from one entity to another in search of care and solutions for their needs; these unnecessary displacements carry financial costs in addition to a decrease in salary and the additional expenses that their care requires" [12]. P4 "... Attending therapies was difficult; I had to do therapies in three parts. In the south, they did therapy in Cali. They did physical therapy here in Palmira in the afternoon. Because of the SOS, I ran out of water therapies before they took me by car. Then, the ARL did not continue to provide transportation, and they did not send me more water because I told the doctor that I was not going to go alone. Cali, it was complicated for me because one was lost, then they did not send me more therapies. I have been without therapy for 3 months...".

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That is, there is also an impact on the worker's economic situation, regardless of whether the event is of labor or common origin.

### End of labor inability

This subcategory was understood as the end of the period of labor inability, when the doctor permitted the worker to return to work.

One important finding related to the labor reintegration process was related to the labor inability and its termination. There is no linear process, only periods of work and remaining at home. Labor inability ends, the worker returns to the workplace and in a short time, returns home due to the labor inability, depending on the health-illness process and medical authorizations.

Labor inability can end for different reasons. One is that the doctor considers that the treatment has reached a point at which the person can resume work, that he or she is again “useful”; this criterion is also mentioned in discussing the dominant medicine and the public power of the doctor in the text Disabling Professions [35].

In some cases, the health-illness process continues even if the period of labor inability has ended; the individual must continue attending his or her ARL or EPS to attend medical appointments, therapies and other treatments, as they did during that period. This situation implies that in addition to the recovery process, work must be carried out, as evidenced in the cases of P1, P2, P6 and P8, who continued with medical follow-up due to the sequelae generated by the precipitating event.

There are also cases where the ARL or EPS doctor ends the labor inability and because the doctor considers that the maximum improvement has been reached. Because of the health event, however, the person returns to his or her workplace with recommendations and initiates follow-up with the company's occupational therapist, as in the case of P3.

Related to the subcategory end of labor inability, it was found that in the process of work reintegration, there are moments when the labor inability has ended, not by the doctor's decision or the worker's suggestion or because the treatment has been terminated, but through interference by ARL or EPS administrative processes that influence the treatment. For example, in the case of P9, who had discontinuous disabilities for approximately 30 months: "At the beginning, I had disabilities of 3 months, 6 months. I went to work 15 days a month, and I became disabled again for 3 months or 2 months. They [The disabilities] were continuous. In total, I was out for 2 and a half years with discontinuous disabilities..." (P9). This comment shows that it is possible for an individual to have several ongoing disabilities that end and begin again.

Ending the period of labor inability for the person can be satisfactory; on some occasions, participants (P1, P2, P3, P4 and P5) mentioned a desire to resume their work and continuously expressed it to the attending physician. When labor inability ended, they mentioned feeling “happiness”, “joy” and the “need to go to work”. This happiness and satisfaction may be related to the fact that the attending physician removes the impossibility of returning to work, and individuals have the possibility to do something again. Returning to work is an important factor in subjective well-being and life satisfaction [19]. However, there may be cases in which the person still does not feel ready to resume work activities, such as that of P11, who reported that the ARL called to tell him that his labor inability period was over, and the decision was made at the request of the organization. P11 said, "... I had many doubts about the type of influence that the company has with respect to the ARL movement and the decision a doctor makes regarding disabilities. It was never clear to me. What was their desire to have me in there? I do not know, doing nothing..."

### Arrival at the workplace

In this subcategory, whether the person was reintegrated with recommendations was considered; occupational recommendations are technical prescriptions made by a health professional as part of their therapeutic process or clinical intervention according to their area of knowledge. “Their objective is to prevent the progression of a specific disease (disease or accident and its consequences)” [36]. For example, doctors may recommend not working night shifts, not lifting loads, etc. This recommendation can change how the person relates to the activity of working, and depending on his or her process and the legalities, they may undergo reintegration with or without modifications, temporary job relocation or permanent job relocation, a situation that implies new learning.

In this case, the health professional (the doctor or specialist) plays an important role in the worker's return to the workplace since it is the doctor who determines what tasks the worker can resume and issues recommendations to adjust the working conditions. These changes may be as simple as a new work chair to accommodate the worker's functions. However, it is possible that sometimes, companies do not consider these medical recommendations, which makes the worker feel unappreciated by the organization when they return. As reported by P1, "... the neuro recommended a different work chair to help me, to resolve the pain, because obviously, I had ended up with posttraumatic pain. When I have a heavy workload, I get stressed. I do not know where to place my neck. So, he said that I must have an
ergonomic chair for my physical well-being. However, I don't have it. I have not seen management. So, I cannot tell you it's been an excellent experience. No, it has not been...

In some cases, workers will perform the same functions or assume the position they held before the health event. There will be a reinstatement with modified functions or a relocation. In other cases, although the changes are not evident, the worker must change how he or she performs work tasks; therefore, it is necessary to review the working conditions before the worker's return. The worker, the immediate supervisor and the organization must work together to assess the competencies that facilitate the worker's return to his or her position.

This discussion allows us to understand that regardless of whether one returns to the same or different working conditions, the return requires continuous support from the organization, supervisors and coworkers because the individual may feel lost, face administrative changes and new coworkers, and no longer have the same work tools available before the health event. For example, P10 talked about adapting to new circumstances, describing an “administrative barrier”; the company did not enable the institutional mail and software he required to manage his work. According to his account, this situation lasted approximately 1 month after his return. In the case of P3, the participant said, “I felt quite strange. I was away from the office for a long time. I arrived again and felt as if I were new, although I had been in my job for a long time.”

**Discussion And Conclusions**

Health is not a state, but rather, it is dynamic because it is related to the changing reality: “reality in this case refers to the material, affective, relational, family and social environment” [37], which is also related to social determinants of health [38].

This qualitative study illuminated the complexity of the labor reintegration process. The process is multidimensional, multitemporal, and nonlinear, with many nuances and characters or actors (organizations, companies providing care and economic services such as ARL and EPS, family, and friends) who participate directly or indirectly and influence the recovery of those who experience an alteration in their health-disease process.

It was also found that this process is more than an administrative procedure that begins with the end of the period of labor inability, as reflected in the Colombian regulations. Instead, the beginning occurs from the moment of the occurrence of the event that alters the worker's health and may end when the attending physician makes his or her recommendations, which may be indefinite. Therefore, the process can be continuous or discontinuous depending on the case.

The phenomenon becomes complex due to all the psychosocial implications. The worker changes their relationship with themselves, with work, family, colleagues, supervisors, and companies, hence the importance of studying the phenomenon in its entirety. In addition, the results help us understand that there are changes in the very reading of the health process and in the economic and social aspects of the work.

To understand this complexity, a broader definition of occupational health is required, namely, as a multidimensional phenomenon that includes the mental health of workers and the social determinants of health. Labor inability is the type of event that involves different actors that are part of these processes (companies providing care and economic services, coworkers, supervisors, administrators, family, friends and the worker). It is necessary to critically analyze, reexamine and redefine the concept of “return to work” and shift toward a more nuanced person-centered approach that recognizes the individual's sense of identity and the importance of work for the individual, the economy, family, work contexts and limitations that exist, given the possible benefits and challenges of returning to work [39].

**Labor reintegration process and its bifurcations**

To show the different ways in which the phenomenon can be understood, narrative lines were used as an explanatory resource to demonstrate that the process of labor reintegration is diverse and has different pathways. This understanding implies referring to reintegration as processes in the plural since the phenomenon does not appear in a single manner and is not always linear; each process depends on the development of another, the experience of each person and the social, organizational and administrative contexts [37].

Five forms of the phenomenon were identified:

**Form 1 - Traditional-Linear Cases**
Some participants (P1, P3, P5, P6, P8, P10, P11) had the experience of being disabled immediately after the occurrence of the health-illness event, ending the period of labor inability and returning to the workplace with medical recommendations. Due to regulatory effects, some types of reinstatement that are stipulated as the norm were presented, such as reinstatement without modifications, reinstatement with modifications, temporary labor relocation, definitive labor relocation or hand reconversion of work, and these workers were not disabled again after their return. If we only take into account these experiences, we could form the impression that the phenomenon is linear, that is, the health event/illness-period of labor inability-termination and return to the workplace (see Illustration 1).

However, a second method of examining the phenomenon (see Illustration 2) shows how changes indicate that the experience is not that sequential for everyone who experiences it.

**Form 2 - Case with interruption of labor inability at the beginning**

One participant (P9) was disabled immediately upon the occurrence of his health-illness event. However, due to issues related to the delay in health system authorizations, his period of labor inability was interrupted; therefore, he had to return to work due to no medical support. Later, due to his health-illness process, he was again incapacitated and later returned to work; this process occurred multiple times (see Illustration 2).

**Form 3 - Case without initial diagnosis**

In this case, a different situation was presented. P4 experienced a health-illness event but was not immediately incapacitated due to the lack of a diagnosis, which implied that the person was working while disabled. “Some clinical physicians perceive temporary labor inability as a swampy terrain in which the same criteria cannot always be applied to the same people or situations. The correct management of temporary incapacity for work requires an adequate diagnosis of health problems, knowledge of legislation and good doctor–patient communication” [34].

**Form 4 - Case of formal labor inability - real work**

In the experience of P2, the occurrence of the health-illness event was immediately disabling. However, during the period of labor inability, P2 was able to work remotely, which does not happen in all cases. This opportunity depends on the worker's position within the organization. In this case, the person is “disqualified” from working remotely due to health-disease issues being violated (see Illustration 4).

**Form 5 - Case between the real and formal work and labor inability** (see Illustration 5). The complexity that has been discussed from the beginning of the paper becomes substantially more evident in this case; one participant (P7) was not immediately incapacitated. Despite having suffered an injury, he continued to work in person. Later, when he was incapacitated, he continued to work in a way. When the period of labor inability ended, he returned to work in person. However, after a period of time due to his health-illness process, he again received medical labor inability benefits, thus starting a cycle of leaving and returning to work. Such an experience in which there are parallel situations (health-illness-nonlabor inability event and work; a period of labor inability-work during the period of labor inability; return to the workplace while the health-disease process continued) reaffirms the necessity of broadening the psychosocial reading of the phenomenon.

Finally, the results of the investigation showed that the beginning of the labor reintegration process occurs before what is proposed in the Colombian regulations (termination of labor inability because the beginning is the occurrence of the health-illness event and this phenomenon is marked by different moments, such as the period of labor inability, the end of labor inability and the return to the workplace with medical recommendations, and reintegration planning). The first step should be to consider the worker’s recovery period, the second step is the initial contact with the worker, the third step is the evaluation of the worker and work tasks, the fourth step is the development of return-to-work plans with accommodations, the fifth step is the resumption of work, and the sixth step is the follow-up after the individual returns to work [1–20, 21, 22].

Taking into account the above, it merits asking at what moments do the work reintegration processes truly begin and end? The end of the process may occur when no additional work-related medical recommendations are given. If so, what happens when the worker does not follow occupational medical recommendations? Will the end be simply when they resume working?

Although each case is presented in a particular manner as seen in the different forms in which the phenomenon can occur, the next stage after the occurrence of the health-illness event tends to be the period of labor inability or time off, i.e., the duration. This period depends on several variables, such as the evolution of the health-disease process of each person, the health system that provides appropriate and
early care of the case, the health system policies, the patient benefits, and the interactions established with the family, social networks, work and the organizational environment.

At times, employers tend to prioritize administrative matters with economic interests over worker health care (EPS and ARL). This point is consistent with the following statement: “... the displacement they [workers] experience between the home and health care entities to attend medical appointments, surgeries, controls and the procedures of these activities, many of which are unnecessary due to lack of clear communication. These displacements are a source of economic wear, loss of time and fatigue in the worker...” [12] and the author's discussion of workers' perceptions: “... workers consider that health and occupational risk entities do not want to assume their case, costs related to their treatments and compensation, which affects their recovery and economic income...” [12].

Thus, in the reading of the processes of labor reintegration, a broader vision of health should encompass the social determinants of health, psychological, biological, social and economic components due to the additional costs; findings concerning the research of the health-disease process [40] imply a call to broaden the reading from safety regulations to occupational health, which shifts the focus of the model from insurability to workers' health.

Work reintegration is a complex, multidimensional, multitemporal and multidirectional phenomenon. It is not a single process. It can involve multiple processes that can be nonlinear, depending on the experiences of those who undergo it and the situational contexts and the organizations where it occurs.

Importantly, this reading of labor reintegration in a context such as Colombia is possible in the context of employment involving modalities such as informality, the service provisions, and independent work where social security is not guaranteed. In the future, it will be important to conduct studies in contexts and countries where the majority of the population is not fully employed to consider public policies for workers' health in all types of work.

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**Author Contributions**

All authors contributed to the study conception and design. Material preparation, data collection and analysis were performed by Ana María Velasco Vivas and Fátima Díaz-Bambula.

The manuscript was written by Ana María Velasco Vivas and Fátima Díaz-Bambula, and all authors commented on previous versions of the manuscript. All authors read and approved the final manuscript.

**Ethics approval**

This study was performed in line with the principles of the deontological and bioethical code of psychology, Law 1090 of 2006, Title II, article 2, paragraphs 6, 9 and Chapter IV, article 49, 50,51 of Colombia were followed [33]

**Consent to participate**

“Informed consent was obtained from all individual participants included in the study.”

**Consent to publish**

The manuscript does not present data, images or videos that reveal the identity of the participants.

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Figures
Figure 1

Narrative Line - Form 1 - Traditional - Linear Cases. Source: Own elaboration.

Figure 2

Narrative Line - Form 1 - Traditional - Linear Cases. Source: Own elaboration.
**Narrative Line. Form 2 - Case with interruption of labor inability at the beginning. Source: Own elaboration.**

_translational and important aspects in the labor reintegration process:

The health-illness process is present at each stage of Work reintegration.

Social Support:
- Family and friends are from the beginning of the health-illness event.
- The organization, bosses and colleagues, appear in some stages of the process such as: ending the period of labor inability and arrival at the workplace.
- The relationship between the health professional who attends the case and the worker is present from the occurrence of the health-illness event.

The health system influences thes provision of healthcare and economic services.

Workers’ attitude is central throughout the process, feelings of uncertainty arise, they feel useless, they worry, they make an effort, they ever demand.

The sense about work become a facilitator of the Work Reintegration Process.

**Figure 3**

**Narrative Line - Form 3 - Case without initial diagnosis. Source: Own elaboration.**

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The sense about work become a facilitator of the Work Reintegration Process.
Figure 4

Narrative Line - Form 4 - Case of formal labor inability real work. Source: Own elaboration.

- The red line indicates that after the health event, the individual continues to work, and subsequently, the period of labor inability occurs.
- The blue line with dots indicates that the person may be in the period of labor inability while also performing work.
- The intermittent green line indicates a return to work with changes in the interaction between the worker and his or her work.
- The curved blue line indicates nonlinearity in the process with respect to the end of the period of labor inability and the return to the workplace since the person can become disabled again while working.

Figure 5

Narrative line - Form 5 - Case between the real and formal aspects of work and labor inability - Source: Own elaboration.

Conventions for reading the Narrative Line - Form 5 - Case between the real and formal work and labor inability